

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16214

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16214

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>DOA. TALBOT</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u><br>c. LENGTH OF STAY IN 1b   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>  |   | d. STREET ADDRESS <u>302 Southway</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>ROBERT BURTON BAKER</u>  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>11 26 1966</u>  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>7/20/49</u>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>  |   | 9b. AGE (In years last birthday) <u>17</u>   | 9c. IF UNDER 1 YEAR<br>Months Days Hours Min.                                    |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>MD.</u>   |  |
| 13. FATHER'S NAME <u>GEORGE W. BAKER, JR.</u>  |   | 14. MOTHER'S MAIDEN NAME <u>JANE PARR</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>  |   | 16. SOCIAL SECURITY NO. <u>230-42-7869</u>   |  |
| 17. INFORMANT <u>GEORGE W. BAKER, JR.</u>  |   | Address <u>(SAME)</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>8164</u><br>DUE TO <u>Fracture of Extremities Head</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2/2/66</u><br>DUE TO <u>Auto Accident</u><br>(c)   |   | INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car hit &amp; fell side of Car thrown</u> |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>9 15 Nov 1966</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>301 USA</u>  | 20f. (City or town) (County) (State)<br><u>Baltimore DOA MD</u>                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE <u>C.R. Layton</u><br>EXAMINER'S NAME (Type) <u>C. R. Layton</u>  |   | 22. DATE SIGNED <u>11-30-66</u><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <u>Centerville, MD</u> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>11/29/1966</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem. Grds.</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Timonium, Balto. Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>  |   | 25a. REC'D BY REGISTRAR <u>NOV 28 1966</u>   |  |
| ADDRESS <u>1905 York Road Baltimore 12, Md.</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |

1801

1802



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16215

## CERTIFICATE OF DEATH

16215

|   |                           |  |                                      |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>TALBOT</b> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>              |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>  |                           | c. LENGTH OF STAY IN lb <b>7 days</b>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print) First <b>SARA</b> Middle <b>C.</b> Last <b>BARTON</b>   |                           | 4. DATE OF DEATH Month <b>11</b> - Day <b>21</b> - Year <b>1966</b>  |                                      |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>JAN 15, 1898</b> |
| 9. AGE (In years last birthday) <b>68</b> yrs.  |                           | 10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>   |                           | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>   |                                      |
| 13. FATHER'S NAME <b>CHARLES CANNON</b>   |                           | 14. MOTHER'S MAIDEN NAME <b>LOTTIE CLINE</b>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                           | 16. SOCIAL SECURITY NO. <b>213-22-7223</b>   |                                      |
| 17. INFORMANT <b>EMMETT BARTON, RIDGELY, MD.</b>  |                           | Address  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br><b>4200</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease with</b><br>DUE TO (c) <b>congestive heart failure</b> |                           | INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 10 minutes</b><br><b>Uncertain</b>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes mellitus with nephropathy</b>   |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11-14-</b> 19 <b>66</b> to <b>11-21-</b> 19 <b>66</b> that (I) (we) lost the deceased alive on <b>11-21-</b> 19 <b>66</b> , and that death occurred at <b>7:30</b> A.M. from causes and on the date stated above.  |                           |  |                                      |
| 22a. SIGNATURE <b>Robert W. Trever</b>  |                           | 22b. DATE SIGNED   |                                      |
| 22c. PHYSICIAN'S NAME (Type)  |                           | 22d. ADDRESS   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                           | 23b. DATE THEREOF <b>NOV 23, 1966</b>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT</b>   |                           | 23d. LOCATION (City or Town) (County) (State) <b>HILLSBORO CAR. MD.</b>  |                                      |
| 24. FUNERAL DIRECTOR <b>Flora M. Morgan</b>   |                           | 25a. REC'D BY REGISTRAR <b>NOV 25 1966</b>   |                                      |
| ADDRESS   |                           | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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U.S. DEPT. OF AGRICULTURE  
WASHINGTON

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16216

16216

|   |                                  |   |  |  |  |   |  |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Talbot</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>27 hrs</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial Hospital</u>  |                                  |   |  | d. STREET ADDRESS<br><u>Teal Point</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>James</u> Middle <u>Castleman</u> Last <u>Beatty</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>Nov</u> Day <u>3</u> Year <u>1966</u>   |  |   |  |
| 5. SEX<br><u>male</u>   | 6. COLOR OF RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-18-87</u>                   | 9. AGE (In years last birthday)<br><u>79</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> |   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired - Accountant</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><u>James Beatty</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Margaret Williams</u> |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Mrs. Margaret Kell Wayne, Pennsylvania</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE RENAL SHUT DOWN</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>SADDLE EMBOLUS OF AORTA</u><br>DUE TO<br>(c) <u>ASHD</u> |                                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 HRS</u><br><u>36 HRS</u><br><u>± 20 YRS</u>             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>TRANS FEMORAL EXTRACTION OF AORTIC EMBOLUS</u>  |                                  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>POST-OP STATE</u>   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-2</u> , 19 <u>66</u> to <u>11-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> , 19 <u>66</u> , and that death occurred at <u>8:45</u> M, from causes and on the date stated above.  |                                  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>John I. F. Knud-Hansen</u>   |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><u>11-4-66</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOHN I. F. KNUD-HANSEN</u>   |                                  |   |  | 22d. ADDRESS<br><u>EASTON, MD 21601</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>11/5/1966</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u>                       |  |
| 24. FUNERAL DIRECTOR<br><u>Wm. J. Turner &amp; Sons</u>   |                                  |   |  | ADDRESS<br><u>Balto., Md.</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>NOV 7 1966</u>   |  |
|   |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES DEPARTMENT OF THE INTERIOR

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16217

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Salisbury</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Kent</u>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>   |   | c. LENGTH OF STAY IN <u>17 1/2</u> days  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hosp.</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>V</u> Last <u>Bill</u>  |   | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>1</u> Year <u>1966</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Colored</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APR 12, 1900</u>                                 |
| 9. AGE (In years last birthday) <u>66</u> yrs.   |   | IF UNDER 1 YEAR: Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  |
| 13. FATHER'S NAME <u>JAMES CURTIS</u>  |   | 14. MOTHER'S MAIDEN NAME <u>EMMETINE JOHNSON</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |   | 16. SOCIAL SECURITY NO. <u>218-01-52180</u>  |  |
| 17. INFORMANT <u>Hospital Records</u>  |   | Address <u>Easton, Md</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br>DUE TO <u>331X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u><br>(c) <u>and Hypertensive cardiovascular disease</u> |   | INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 24 Hrs.</u><br><u>Unknown</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE <u>Robert W. Trever</u>   |   | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>   |   | 22d. ADDRESS <u>Easton, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   | 23b. DATE THEREOF <u>11-4-66</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>CHESTER CEMETERY</u>   | 23d. LOCATION (City or Town) (County) (State) <u>CHESTER KENT Md</u> |
| 24. FUNERAL DIRECTOR <u>Sam H. Banta Jr., Banta Bros., Chesterville, Md.</u>   |   | 25a. REC'D BY REGISTRAR <u>NOV 7 1966</u>  |  |
|  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16218

16218

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Talbot</u> <u>MARYLAND</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>                |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>   |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>   |  |  |  |
| c. LENGTH OF STAY IN 1b <u>Lifetime</u>  |  |  |  | d. STREET ADDRESS <u>422 August Street</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>422 August Street</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Mildred Elizabeth Chance</u>  |  |  |  | 4. DATE OF DEATH <u>Nov. 30 1966</u>   |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>May 19, 1897</u>                               |  |
| 9. AGE (In years last birthday) <u>69</u> yrs.   |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  |
| 13. FATHER'S NAME <u>Charles M. T. Soulsby</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Katie Golt</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <u>218-20-5374B</u>  |  |  |  |
| 17. INFORMANT <u>James L. Chance, 12 Choptank Ave. Easton, Md.</u>   |  |  |  | Address <u>  </u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO (b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>  </u> <u>  </u> <u>19</u>  |  | 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |  | 20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Louis Welch</u>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type) <u>WELCH</u>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| M.D. <u>  </u>   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| Address (Street, city, town, or county) <u>  </u>  |  |  |  | DATE SIGNED <u>12-1-66</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>12/2/1966</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>   |  |
| 23. FUNERAL DIRECTOR <u>MAURICE E. NEWMAN &amp; SON, Easton, Md.</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |  |
| DATE <u>DEC 2 1966</u>   |  |  |  |  |  |  |  |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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|   |                                  |   |   |   |   |   |  |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Talbot</u> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>3 days</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Federalsburg</u>                                     |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial Hospital</u>  |                                  |   |   | d. STREET ADDRESS<br><u>North Main Street</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mrs. Mary</u> Middle <u>Stant</u> Last <u>Clague</u>  |                                  |   |   | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>23</u> Year <u>1966</u>  |   |   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>October 11, 1876</u> |   | 9. AGE (In years last birthday)<br><u>90</u> yrs. | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Queen Anne's County, Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>George W. Stant</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Jane Atkinson</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>217-12-4921</u>   |   | 17. INFORMANT<br>Address<br><u>Mrs. Cora Fluharty, Federalsburg, Md.</u>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive upper gastro-intestinal</u><br><u>5400</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>bleeding</u><br>DUE TO (c) <u>Peptic ulcer</u> |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u><br><u>(?)</u>                                   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |                                  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>20 Nov</u> , 19 <u>66</u> , to <u>23 Nov</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>22 Nov</u> , 19 <u>66</u> , and that death occurred at <u>1:15</u> A.M. from causes and on the date stated above.  |                                  |   |   |   |   |   |  |
| 22a. SIGNATURE<br><u>Thurston Harrison</u>  |                                  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>             |   | 22b. DATE SIGNED<br><u>23 Nov 66</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>THURSTON HARRISON</u>  |                                  |   |   | 22d. ADDRESS<br><u>Easton, Maryland</u>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>11-25-66</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hill Crest Cemetery</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Federalsburg, Maryland</u>                    |  |
| 24. FUNERAL DIRECTOR<br><u>J. J. Hampton &amp; Son Federalsburg, Md.</u>  |                                  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>NOV 28 1966</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIPT OF DEBIT

Received of  
Mrs Mary  
Thompson  
the sum of  
Twenty  
Dollars  
for  
rent

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Received of  
Mrs Mary  
Thompson  
the sum of  
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Received of  
Mrs Mary  
Thompson  
the sum of  
Twenty  
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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MV-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Talbot</i>  |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br><i>Maryland</i> |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>St. Michaels</i>  |  | b. COUNTY<br><i>Talbot</i>   |  |
| c. LENGTH OF STAY IN 1b<br><i>DOA</i>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Easton (rural)</i>            |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Talbot Street</i>   |  | d. STREET ADDRESS<br><i>20.1</i>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>Olin Oscar Daffin</i>   |  | 4. DATE OF DEATH<br><i>11/21 1966</i>  |  |
| 5. SEX<br><i>male</i>  |  | 6. COLOR OR RACE<br><i>white</i>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><i>2/9/1910</i>  |  |
| 9. AGE (In years last birthday)<br><i>56</i> yrs.  |  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Mason</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Carpentry</i>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 13. FATHER'S NAME<br><i>Arthur Daffin</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Annie Mielke</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>Yes</i>  |  | 16. SOCIAL SECURITY NO.<br><i>218-03-2942</i>  |  |
| 17. INFORMANT<br><i>Mrs. Olin O. Daffin, Easton, Md. RFD</i>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary occlusion</i><br><i>4201</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><i>19</i>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>Louis O. Merty</i><br>EXAMINER'S NAME (Type)<br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><i>11-22-66</i> |  | DATE SIGNED  |  |
| 22a. BURIAL, CREMATION, or other disposition (Specify)<br><i>Buried</i>  |  | 22b. DATE THEREOF<br><i>11/23/1966</i>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Memorial Park</i>  |  | 22d. LOCATION (City, town, or county) (State)<br><i>Easton, Md.</i>  |  |
| 23. FUNERAL DIRECTOR<br><i>MAURICE E. NEUNHAM &amp; SON, Easton, Md.</i>   |  | ADDRESS  |  |
| 24a. REC'D BY REGISTRAR<br>DATE<br><i>NOV 23 1966</i>  |  | 24b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |   |  |  |   |   |   |  |
|--|--|-------------------------------|---|--|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |   |  |  |   |   |   |  |
| 16221 CERTIFICATE OF DEATH 16221   |  |                               |   |  |  |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>TALBOT</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>EASTON</b><br>c. LENGTH OF STAY IN 1b <b>7-30-66</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOUSE IN THE PINES, INC. EASTON</b>  |  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>*TALBOT*</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Centreville</b><br>d. STREET ADDRESS <b>RT. 3 * BX 95</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |  |
| 3. NAME OF DECEASED (Type or print) <b>THOMAS</b>  |  |                               | First Middle Last <b>HAROLD DAVIS</b>   |  |  | 4. DATE OF DEATH <b>11-7-66</b>                                     |   | Day Year <b>19</b>  |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Jan. 28, 1880</b>                               |   | 9. AGE (In years last birthday) <b>86</b> yrs.                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker</b>  |  |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                             |  |
| 13. FATHER'S NAME <b>Thomas Davis</b>  |  |                               |   |  | 14. MOTHER'S MAIDEN NAME <b>Susan Baynard</b>  |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>   |  |                               | 16. SOCIAL SECURITY NO. <b>220-44-8809</b>  |  | 17. INFORMANT <b>Mrs. T. H. Davis--Centreville, Md.</b> Address  |   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>R L L pneumonia</b><br><b>490X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                               |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>2 weeks</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                      |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1 Sep</b> , 19 <b>66</b> , to <b>7 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-1</b> , 19 <b>66</b> and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.  |  |                               |   |  |  |   |   |   |  |
| 22a. SIGNATURE <b>Stephen P. Carney</b>  |  |                               |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>7 Nov 66</b>  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Stephen P. Carney</b>  |  |                               |   |  | 22d. ADDRESS <b>Easton, Maryland</b>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                               | 23b. DATE THEREOF <b>Nov 10</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield</b>   |   | 23d. LOCATION (City, town or county) (State) <b>Centreville, Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR <b>Edgar L. Lane Church Hill Md</b> ADDRESS   |  |                               |   |  | 25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>                         |   |  |

MEDICAL CERTIFICATION

ISSN 1

1992

151

• **Index**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16222

CERTIFICATE OF DEATH

17814

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Talbot</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>   |  | c. LENGTH OF STAY IN 1b<br><u>12 days.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial Hospital</u>  |  | d. STREET ADDRESS<br><u>Near Smithville</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Mr. WATMAN George Dolby</u>  |  | 4. DATE OF DEATH <u>11-29-1966</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1880</u>   |
| 9. AGE (In years last birthday)<br><u>86</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Dorchester County, Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Hiram Dolby</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>215-16-8077</u>   |  |
| 17. INFORMANT<br><u>Mrs. Florence A. Dolby, Federalsburg, Md.</u>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart Failure</u><br>DUE TO (b) <u>Atherosclerotic Heart Disease</u><br>DUE TO (c) <u>Years.</u>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>66</u> , to <u>11/29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/28</u> , 19 <u>66</u> , and that death occurred at <u>2:50</u> A.M. from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><u>S. KRECH, JR.</u>  |  | 22b. DATE SIGNED<br><u>11/29/66</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>S. KRECH, JR.</u>  |  | 22d. ADDRESS<br><u>EASTON, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>12-3-66</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Bloomery Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Near Federalsburg, Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Trampten Funeral Home Federalsburg</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 8 1966</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |

17814

DEPARTMENT OF HEALTH

100000

Residence

Married

Occupation

Place of birth

Place of birth

Age

Sex

Mr. William J. Smith

White

Male

Height

Weight

Build

Complexion

Scars

Age

Height

3 weeks

Heart failure

from

the aorta, heart disease

22 11/2 22 11/2 22 11/2

22 11/2 22 11/2

22 11/2 22 11/2

W. J. Smith

W. J. Smith

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

162228

## CERTIFICATE OF DEATH

16222

|  |                                    |   |   |   |   |   |  |
|--|------------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>What</u> MARYLAND  |                                    |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>  |                                    |   |   | c. LENGTH OF STAY IN 1b<br><u>7 days</u>  |   |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton - Rt. 2</u>  |                                    |   |   | 201   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial Hospital</u>   |                                    |   |   | d. STREET ADDRESS<br>_____  |   |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |   |   |   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle <u>Henry</u> Last <u>Fletcher</u>   |                                    |   |   | 4. DATE OF DEATH<br>Month <u>Nov.</u> Day <u>14</u> Year <u>1966</u>  |   |   |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><u>MAR. 2, 1896</u> | 9. AGE (In years last birthday)<br><u>70</u> yrs.   | IF UNOER 1 YEAR<br>Months Days Hours Min. |   | IF UNOER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>hacker</u>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Domestic</u>  |   | 11. BIRTHPLACE (County & State or foreign country)<br><u>Talbot, Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Anderson Fletcher</u>  |                                    |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Emma Cherry</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                    | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><u>Hospital Records Easton, Md</u>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>UREMIA, CHRONIC</u><br>DUE TO <u>609X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>CHRONIC PYELONEPHRITIS</u><br>DUE TO <u>YRS</u><br>(c) <u>PERIURETHRAL ABSCESS</u><br>DUE TO <u>35 years</u> |                                    |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)  |                                    |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (1) (this hospital) attended the deceased from _____, 19 <u>66</u> , to <u>11-13-</u> , 19 <u>66</u> , that (2) (we) last saw the deceased alive on <u>11-14</u> 19 <u>66</u> and that death occurred at <u>5:00 AM</u> , from causes and on the date stated above.   |                                    |   |   |   |   |   |  |
| 22a. SIGNATURE<br><u>Richard F. Tyson</u>  |                                    |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>           |   | 22b. DATE SIGNED<br><u>11-14-66</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>RICHARD F. TYSON</u>  |                                    |   |   | 22d. ADDRESS<br><u>36 S. AURORA ST EASTON MD 21601</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                    | 23b. DATE THEREOF   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |
| <u>BURIAL</u>  |                                    | <u>11-16-66</u>   |   | <u>CHAPEL Cemetery</u>  |   | <u>Talbot Md</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Herbert Dashiell, Easton, Md</u>  |                                    |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>NOV 17 1966</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1853

DEATH OF MARY

1853

TO THE SECRETARY OF THE  
NAVY  
WASHINGTON  
D. C.



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17820 PC - 11  $\frac{15}{4M}$

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>TALBOT</b>   |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>EASTON</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>9 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Preston</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>RT# 2, Box# 151</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Annie</b> Middle <b>Maude</b> Last <b>Hamilton</b>  |                                  | 4. DATE OF DEATH<br>Month <b>11</b> - Day <b>30</b> Year <b>1966</b>  |  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 6, 1914</b> | 9. AGE (In years last birthday) yrs.<br><b>52</b>   | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Household</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  | 13. FATHER'S NAME<br><b>Not known</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Not Known</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>64-36-8441</b>  |  | 17. INFORMANT<br><b>Alex Saulsbury, RT #2, Box 151, Preston, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b><br>9040<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fract hip left</b><br>(c) <b>9 days.</b>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days.</b>  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><b>Prostatitis</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> - <b>Probable</b><br>CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>? Pt. lived alone</b>                                    |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br><b>11 15 am 11-30-1966</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>home</b>   |   |
| 20f. (City or town) (County) (State)   |                                  | 20g. (City or town) (County) (State)  |  | 20h. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |  |   |   |
| ACTUAL SIGNATURE<br><b>Howard F. Kinnamon Jr.</b>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | 22. DATE SIGNED   |   |
| EXAMINER'S NAME (Type)<br><b>HOWARD F. KINNAMON JR.</b>  |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | Address (Street, city, town, or county)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>   |                                  | 23b. DATE THEREOF<br><b>12-6-1966</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pinetown Cemetery</b>  |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Pinetown, Md. Caroline</b>   |                                  | 23e. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |  | 23f. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>George H. Lashell, Easton Md.</b>   |                                  | 24a. ADDRESS<br><b>Easton Md.</b>   |  | 24b. DATE<br><b>DEC 8 1966</b>  |   |

15280

MADE IN U.S.A. & CANADA

15280

MADE IN U.S.A. & CANADA

MADE IN U.S.A. & CANADA

MADE IN U.S.A. & CANADA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 16225   |  |  |  |  |  | 16223  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>TALBOT</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MICHAELS</b><br>c. LENGTH OF STAY IN 1b <b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rio Vista Nursing Home</b> |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTER</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>HUGH</b> First <b>TIMMS</b> Middle <b>HARRIS</b> Last<br>4. DATE OF DEATH <b>Nov. 18</b> Month <b>18</b> Day <b>19</b> Year <b>66</b>  |  |  |  |  |  | 5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>SEPT. 20-1886</b> 9. AGE (in years last birthday) <b>80</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER AND WATERMAN</b> 10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                       |  |  |  |  |  | 13. FATHER'S NAME <b>J. HUGH HARRIS</b> 14. MOTHER'S MAIDEN NAME <b>DEBORAH TIMMS</b>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <b>226-32-0455</b> 17. INFORMANT <b>ELLIOTT HARRIS - CHESTER MD.</b> Address  |  |  |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>332 x DUE TO <b>cerebral atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)   |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>31 July</b> , 19 <b>66</b> , to <b>18 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1 Nov</b> , 19 <b>66</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.         |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>Thurston Harrison</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>21 Nov 66</b>  |  |  |  |  |  | 22c. PHYSICIAN'S NAME (Type) <b>THURSTON HARRISON</b> 22d. ADDRESS <b>Chester, Maryland</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>Nov. 21</b> 23c. NAME OF CEMETERY OR CREMATORY <b>STEVENSVILLE</b> 23d. LOCATION (City, town or county) (State) <b>STEVENSVILLE MD.</b>  |  |  |  |  |  | 24. FUNERAL DIRECTOR <b>Edgar D. Lane</b> ADDRESS <b>CHURCH HILL MD.</b> 25a. REC'D BY REGISTRAR <b>Nov 25 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |  |  |

SS01

112221

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16226

CERTIFICATE OF DEATH

16224

|  |                                  |   |  |   |  |   |  |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Talbot</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>  |                                  |   | c. LENGTH OF STAY IN 1b  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hurlock</u> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial Hospital</u>   |                                  |   |  | d. STREET ADDRESS   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Rafas</u> Middle <u>Nelson</u> Last <u>Horsey</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>3</u> Year <u>1966</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 22, 1895</u>  |   | 9. AGE (In years last birthday)<br><u>71</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired U.S. Govt. Employee-General Services ADM.</u>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Crisfield, Md.</u>                       |   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                  |   | 13. FATHER'S NAME<br><u>Joshua R. Horsey</u>   |   |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Ida M. Sterling</u>   |                                  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u> |   |  |   |  |
| 16. SOCIAL SECURITY NO.<br><u>Unknown</u>  |                                  |   | 17. INFORMANT<br><u>Mrs. Alda M. Horsey, Hurlock, Maryland</u>   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) DUE TO |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 Oct 66</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Hemorrhoidectomy 30 Oct 66</u>   |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>28 Sep</u> , 19 <u>66</u> , to <u>3 Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2 Nov</u> , 19 <u>66</u> , and that death occurred at <u>8:32 M</u> , from causes and on the date stated above.                |                                  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><u>Stephen P. Carney</u>   |                                  |   | 22b. DATE SIGNED<br><u>11-3-66</u>   |   | 22c. PHYSICIAN'S NAME (Type)<br><u>Stephen P. Carney</u>   |   |  |
| 22d. ADDRESS<br><u>Easton, Md.</u>   |                                  |   | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>Nov. 7, 1966</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln Cemetery</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Colmar Manor, Maryland</u>                     |   |  |
| 24. FUNERAL DIRECTOR<br><u>Trampton Funeral Home Federal City</u>  |                                  |   | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10834

STATE OF TEXAS

10834

NOTARY PUBLIC

NOTARY PUBLIC

NOTARY PUBLIC

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16227

CERTIFICATE OF DEATH

16225

|   |                              |   |                                |
|---|------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Talbot</u> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>               |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Exstox 4 wks.</u>             |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - LINAS ROAD</u>  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>             |                              | d. STREET ADDRESS <u>Church Creek, Md.</u>  |                                |
| 3. NAME OF DECEASED<br>(Type or print) <u>MARSHA</u> First <u>M</u> Middle <u>HUNT</u> Last                       |                              | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>7</u> Year <u>1966</u>   |                                |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-6-66</u> |
| 9. AGE (In years last birthday) yrs. <u>5</u>   |                              | IF UNDER 1 YEAR<br>Months <u>5</u> Days <u>1</u>  |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>           |                              | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>   |                                |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Md.</u>                                    |                              | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>  |                                |
| 13. FATHER'S NAME <u>DONALD LEE</u>   |                              | 14. MOTHER'S MAIDEN NAME <u>LAVADIA HUNT</u>  |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) |                              | 16. SOCIAL SECURITY NO. <u>NONE</u>   |                                |
| 17. INFORMANT <u>LAVADIA HUNT</u> Address <u>SAME</u>   |                              |   |                                |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>7545 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Malformation of Heart</u><br>DUE TO (c) <u>Mongolism</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 mo</u><br><u>since Birth</u><br><u>11</u> |
|---|--|--|

|  |   |   |
|--|---|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                    |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |
| 20f. (City or town) (County) (State)   |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-12</u> , 19 <u>66</u> , to <u>11-7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-7</u> , 19 <u>66</u> , and that death occurred at <u>11:55</u> M, from causes and on the date stated above. |   |   |
| 22a. SIGNATURE <u>John E. Baybutt</u> M.D.   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>11-8-66</u>   |
| 22c. PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u> M.D.   | 22d. ADDRESS <u>205 Earl and Easton Md.</u>   |   |

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11/9/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LINAS ROAD</u> | 23d. LOCATION (City or Town) (County) (State) <u>Dorchester Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Frederick C. Hagan</u>         |                                  | 25a. REC'D BY REGISTRAR <u>Cambridge Md.</u>         |   |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>        |                                  | DATE <u>NOV 14 1966</u>                              |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10832

CERTIFICATE OF DEATH

10832

Name of father on death cert. does not agree with name  
on birth certificate: Affidavits needed to make change -  
12/6/66-MB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 5-63

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>e. COUNTY <b>TALBOT</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>e. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>                   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>WITTMAN</b>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>WITTMAN</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>RURAL</b>   |   | d. STREET ADDRESS<br><b>RURAL</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ELLIS G JONES</b>   |   | 4. DATE OF DEATH<br>Month <b>NOV</b> Day <b>8</b> Year <b>1966</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUGUST 15, 1898</b> |
| 9. AGE (In years last birthday)<br><b>68</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WATERMAN</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SEA FOOD</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>WITTMAN MD</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JOHN W. JONES</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>SARA ELIZABETH MARSHALL</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>218-05-8396</b>   |  |
| 17. INFORMANT<br><b>Elbert Jones Wittman, 2nd</b>  |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO (b) <b>Arteriosclerotic Cardiovascular</b><br>(c) <b>Hypertensive Melitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b><br><b>10 yr.</b><br><b>15 yr.</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)       |
| 21. I certify that (I) (his hospital) attended the deceased from <b>Aug 2, 1966</b> to <b>Nov 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 5, 1966</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>R. Paul Wright</b>  |   | 22b. DATE SIGNED<br><b>11-10-66</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)   |   | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |   | 23b. DATE THEREOF<br><b>NOV 11, 1966</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>OLIVET CEMETERY</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>ST. MICHAEL'S MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hambleton Harrison, Jr. Michael</b>   |   | 25a. REC'D BY REGISTRAR<br><b>NOV 14 1966</b>   |  |
| ADDRESS<br><b>md.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

8558

16880

CENTRAL OF ILL.

8558

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16229

CERTIFICATE OF DEATH

16227

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>TALBOT</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>   |  | c. LENGTH OF STAY IN 1b <u>10 1/2 hours</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Mrs. Anna Spence Mace</u>   |  | 4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1966</u>  |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT 10, 1879</u>                                    |
| 9. AGE (In years last birthday) <u>87</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED HOUSEWIFE</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPING</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>DORCHESTER MD</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |   |
| 13. FATHER'S NAME <u>JOHN SELBY</u>  |  | 14. MOTHER'S MAIDEN NAME <u>MARY HENRY SPENCE</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>718-48-5336</u>   |   |
| 17. INFORMANT <u>MRS. V. HOWARD ANTHONY</u> Address <u>303 S. WASHINGTON ST EASTON</u>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br><u>5702</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anteroseptal heart disease</u><br>DUE TO (c) <u></u> |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u><br><u>YRS</u>             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>13 Nov</u> , 19 <u>66</u> , to <u>14 Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>13 Nov</u> 19 <u>66</u> , and that death occurred at <u>1:30 PM</u> , from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE <u>Stephen P. Carney</u> M.D.   |  | 22b. DATE SIGNED <u>11-15-66</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u> M.D.   |  | 22d. ADDRESS <u>Easton, Maryland</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>NOV 16, 1966</u>  | 23b. DATE THEREOF <u>NOV 16, 1966</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>EAST NEW MARKET</u>  | 23d. LOCATION (City or Town) (County) (State) <u>EAST NEW MARKET MD</u> |
| 24. FUNERAL DIRECTOR <u>Charles Judge</u> Address <u>Easton, MD</u>  |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |
| DATE <u>NOV 17 1966</u>  |  |  |   |

16887

CERTIFICATE OF DEATH

16887

10:10 AM

10:10 AM

10:10 AM

10:10 AM

10:10 AM



VR A15 (4)  
20 M 1/66

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Talbot</u>  |                                  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>4 hrs.</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u> <u>201</u>                              |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial Hospital</u>  |                                  |   | d. STREET ADDRESS<br><u>221 S. Aurora Street</u>                  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Robert Milton Reeves</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>6</u> Year <u>1966</u> |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><u>3/14/1879</u>                              |   | 9. AGE (In years last birthday) yrs. <u>87</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Crane operator</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Chem. Co.</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Queen Anne Maryland</u>   |   |
| 13. FATHER'S NAME<br><u>Robert M. Reeves</u>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                        |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |                                  |   | 16. SOCIAL SECURITY NO.<br><u>216-24-3856</u>                     |   |   |
| 17. INFORMANT<br><u>Mrs. Charles T. Marshall, Easton, Md.</u>   |                                  |   | Address   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac asthma</u><br><u>4200</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Left ventricular failure</u><br>DUE TO<br>(c) <u>Arteriosclerotic heart disease</u> |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>less than 8 hours</u><br><u>Unknown</u>                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Chronic obstructive emphysema. Chronic asthmatic bronchitis.</u>   |                                  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   |
| 20f. (City or town) _____ (County) _____ (State) _____  |                                  |   |   |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>8:25</u> AM, from causes and on the date stated above  |                                  |   |   |   |   |
| 22a. SIGNATURE<br><u>Robert W. Trever</u>   |                                  |   |   | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Robert W. Trever</u>   |                                  |   |   | 22d. ADDRESS<br><u>Easton, Md. Rte. 50R Dutchman's Lane</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>11/8/1966</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Spring Hill</u>  |   |
| 23d. LOCATION (City or Town)<br><u>Easton, Md.</u>  |                                  | (County) _____ (State) _____  |   |   |   |
| 24. FUNERAL DIRECTOR<br><u>Maurice E. Newman, Son</u>   |                                  | ADDRESS<br><u>Easton, Md.</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>NOV 9 1966</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                  |   |   |   |   |

10554

10554

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 1043  
AUTHORITY 105-10-100-100

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16231

## CERTIFICATE OF DEATH

16229

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>TALBOT</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admittance)<br>a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNES</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>EASTON</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wye Mills</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial</u>   |   | d. STREET ADDRESS<br><u>172</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Emory</u> Middle <u>Theodore</u> Last <u>Roe</u>  |   | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>24</u> Year <u>1966</u>  |  |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 21, 1896</u>   |
| 9. AGE (In years last birthday)<br><u>70</u> yrs.   |   | 10. UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Inspector</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Reads Commission</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Wye Mills, D.A.C., Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>John B. Thomas</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Valencia (Winie) Graham MacFarlan</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>218-05-8154</u>   |  |
| 17. INFORMANT <u>Wife</u>   |   | Address<br><u>Mrs. Ruth P. Roe, Wye Mills, Maryland</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u><br>DUE TO <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Acute myocardial infarction</u><br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>5 days</u>                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u><br>p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>21 Nov</u> , 19 <u>66</u> , to <u>24 Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>24 Nov</u> , 19 <u>66</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><u>Stephen P. Carney</u>  |   | 22b. DATE SIGNED<br><u>11-25-66</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Stephen P. Carney</u>  |   | 22d. ADDRESS<br><u>Easton, Maryland</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Nov. 26, 1966</u>   | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Chesterfield Cemetery</u>  | 23d. LOCATION (City or town) (County) (State)<br><u>Centerville, D.A.C., Md.</u>       |
| 24. FUNERAL DIRECTOR<br><u>James H. Barton Jr., Barton Bros., Centerville, Md.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>NOV 28 1966</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10552

10552

4 days

Emory Theodore Roe 11/34 pp

pp

DATE

NO.

NO.

NO.

NO.

NO.

NO.

NO.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

| <div> <div> <div>1M</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>16232</div> <div>Items 8,9 Film G383 12/2/66 mh</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>16230</div> </div> </div>   |  |                                  |  |   |  |   |  |  |  |   |  |
|---|--|----------------------------------|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>TALBOT</b>   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>QUEEN ANNE'S</b>    |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CHESTER</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WITTMAN</b>  |  |                                  |  | c. LENGTH OF STAY IN lb   |  |   |  | d. STREET ADDRESS<br><b>17-2</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |                                  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>JAMES WALTER ROE</b>   |  |                                  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>NOVEMBER 26 1966</b>   |  |   |  |  |  |   |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 23, 1936</b>   |  | 9. AGE (In years last birthday)<br><b>30 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                       |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>            |  |
| 13. FATHER'S NAME<br><b>RICHARD ROE</b>   |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>MAMIE THOMAS</b>   |  |   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |                                  |  | 16. SOCIAL SECURITY NO.<br><b>214-36-5494</b>   |  |   |  | 17. INFORMANT<br><b>MRS. JAMES ROE - WITTMAN MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIAATION- BODY MOSTLY CONSUMED IN FIRE</b><br><b>916.0</b> DUE TO <b>HOUSE BURNED DOWN COMPLETELY</b><br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>(e), stating the underlying cause last.   |  |                                  |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  |                                  |  |   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)<br><b>SLEEPING IN HOUSE THAT BURNED DOWN</b>                   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>? 1A p.m. 11-26 1966</b>  |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>HOME</b> |  | 20f. (City or town)<br><b>WITTMAN</b>  |  | (County) (State)<br><b>TALBOT MD</b>                  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                  |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Louis S. Welty</b>   |  |                                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | DATE SIGNED<br><b>11-26-66</b>   |  |   |  |
| EXAMINER'S NAME (Type)<br><b>LOUIS S. WELTY</b>   |  |                                  |  | M.D.<br>FOR DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  | Address (Street, city, town, or county)  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |                                  |  | 22b. DATE THEREOF<br><b>Nov. 28</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>STEVENSVILLE</b>                             |  | 22d. LOCATION (City, town, or county) (State)<br><b>STEVENSVILLE MD.</b>                           |  |   |  |
| 23. FUNERAL DIRECTOR<br><b>Edgar d. Lane</b>  |  |                                  |  |   |  | ADDRESS<br><b>CHURCH HILL MD.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>NOV 29 1966</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b> |  |

MEDICAL CERTIFICATION

10880

10880

X

DATE

TIME

NAME

NAME

10880

10880

10880

10880

10880

10880

X

X

X

X

X



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16233

16231

|  |  |   |   |  |   |  |  |
|--|--|---|---|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Talbot</b> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b><br>c. LENGTH OF STAY IN b. <b>10 yrs</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>-----</b>                              |  |   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b><br>d. STREET ADDRESS <b>-----</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>ROBERT F. SCHELLS</b>   |  | <b>4. DATE OF DEATH</b><br>Month <b>November</b> Day <b>23</b> Year <b>1966</b>   |   |  |   |  |  |
| <b>5. SEX</b><br><b>Male</b>   | <b>6. COLOR OR RACE</b><br><b>White</b>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>July 22, 1915</b>         | <b>9. AGE</b> (In years last birthday) <b>51</b> yrs.<br><b>IF UNDER 1 YEAR</b> Months <b>-----</b> Days <b>-----</b><br><b>IF UNDER 24 HRS.</b> Hours <b>-----</b> Min. <b>-----</b>  |   |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Life Insurance Agent</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Insurance</b>  |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Talbot County, Maryland</b>   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b> |  |  |
| <b>13. FATHER'S NAME</b><br><b>Francis H. Schells</b>  |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Addie Plummer</b> |  |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>-----</b>   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>212-14-4514</b>  |   | <b>17. INFORMANT</b><br><b>Rio Vista</b><br><b>Mrs. Robert F. Schells, St. Michaels, Md.</b>   |   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>4201 DUE TO <b>atherosclerotic coronary a.t.f.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>-----</b> |  |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>30 min</b>   |   |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>  |  |   |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>-----</b>  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |   | <b>20f. (City or town)</b><br><b>St. Michaels, Maryland</b>  | <b>(County)</b><br><b>-----</b>                   |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1953</b> <b>11-23-66</b> , that (I) <b>(was)</b> last saw the deceased alive on <b>11-23-66</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.  |  |   |   |  |   |  |  |
| <b>22a. SIGNATURE</b><br><b>GUY M. REESER, Jr., M.D.</b>   |  | <b>22b. DATE SIGNED</b><br><b>11-25-66</b>  |   | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>GUY M. REESER, Jr., M.D.</b>   |   |  |  |
| <b>22d. ADDRESS</b><br><b>St. Michaels, Maryland</b>   |  | <b>22e. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b><br><b>DATE NOV 29 1966</b> <b>Charles Judge</b>  |   |  |   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |  | <b>23b. DATE THEREOF</b><br><b>Nov 26, 1966</b>   |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Olivet Cemetery</b>  |   |  |  |
| <b>23d. LOCATION</b> (City, town or county)<br><b>St. Michaels, Maryland</b>   |  | <b>(State)</b><br><b>-----</b>  |   |  |   |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Hamilton Harrison</b>  |  |   |   |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16234

16232

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Easton</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Henderson</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial Hospital</u>   |                                  | d. STREET ADDRESS<br><u>None</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Edward</u> Middle <u>Robert</u> Last <u>Thomas</u>  |                                  | 4. DATE OF DEATH<br>Month <u>Nov.</u> Day <u>21</u> Year <u>1966</u>   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><u>June 2, 1885</u> |
| 9. AGE (in years last birthday)<br><u>81</u> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u></u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>James E. Thomas</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Mollie Wooleyhan</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>217-30-8519</u>  |   |
| 17. INFORMANT<br><u>Mae Thomas Henderson, Maryland</u>   |                                  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Vascular collapse</u><br>5702 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Decomposition thromboses &amp; gangrene of colon</u><br>DUE TO<br>(c) <u>+ Embolus to right leg</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u><br><u>11 days</u><br><u>8 days</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u> p.m. <u></u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>66</u> , to <u>11/21</u> , 19 <u>66</u> that (I) <del>was</del> last saw the deceased alive on <u>11/20</u> , 19 <u>66</u> , and that death occurred at <u>3:04</u> M, from causes and on the date stated above.  |                                  |  |   |
| 22a. SIGNATURE<br><u>J. T. B. Ambler</u>   |                                  | 22b. DATE SIGNED<br><u>11/22/66</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>J. T. B. Ambler</u>   |                                  | 22d. ADDRESS<br><u>M. D. Easton, Maryland</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>11-24-66</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greensboro</u>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Greensboro, Maryland</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>J. E. Boulais Greensboro, Md.</u>   |                                  | 25a. REC'D BY REGISTRAR<br><u>NOV 25 1966</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                                  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10538

CENTRAL OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16235

CERTIFICATE OF DEATH

16233

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>TALBOT</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>          |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>   |                               | c. LENGTH OF STAY IN 1b <u>1 day</u>   |                                       |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>   |                               | 17-3   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>  |                               | d. STREET ADDRESS  |                                       |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>N</u> Last <u>TREZISE</u>   |                               | 4. DATE OF DEATH<br>Month <u>NOV</u> Day <u>3</u> Year <u>1966</u>   |                                       |
| 5. SEX <u>Female</u>   | 6. COLOR OF RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 25, 1905</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs.   |                               | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |                                       |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>American Legion</u>   |                                       |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co. Md.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |                                       |
| 13. FATHER'S NAME <u>Richard Trezise</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Annie Murphy</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>220-01-2246</u>   |                                       |
| 17. INFORMANT <u>Joan Sellers</u>  |                               | Address <u>202 Kidwell Ave. - Centerville Md.</u>  |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br><u>331X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>about 3 1/2 hrs.</u><br>DUE TO (c) |                               | INTERVAL BETWEEN ONSET AND DEATH   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>3:57</u> M, from causes and on the date stated above.  |                               |  |                                       |
| 22a. SIGNATURE <u>Robert W. Trever</u>   |                               | 22b. DATE SIGNED <u>11/3/66</u>  |                                       |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>   |                               | 22d. ADDRESS <u>M.D. Easton, Maryland</u>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>11-7-66</u>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>  |                               | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>   |                                       |
| 24. FUNERAL DIRECTOR <u>Edgar L. Lane Church Hill Md.</u>  |                               | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |                                       |
| 25b. REGISTRAR'S SIGNATURE   |                               | DATE <u>NOV 7 1966</u>   |                                       |

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CONTINUED ON REVERSE

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side. Some fragments are visible, such as "THE FOLLOWING", "IN THE", and "ON THE".]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |  |  |  |  |   |   |  |
|--|--|--|---|--|--|--|--|--|---|---|--|
| 16236  |  |  |   |  |  | 16234  |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>TALBOT</b>  |  |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>DORCHESTER</b> |  |  |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>EASTON</b>  |  |  |   | c. LENGTH OF STAY IN 1b<br><b>8 Months</b> |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge</b>   |  |  |   | d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>HOUSE IN THE PINES EASTON</b>   |  |  |   |  |  | d. STREET ADDRESS<br><b>ROUTE #3 Box 255</b>   |  |  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>CORA Gleason WHEATLEY</b>  |  |  | 4. DATE OF DEATH<br><b>NOV. 26 1966</b>   |  |  | 5. SEX<br><b>F</b>   |  |  | 6. COLOR OR RACE<br><b>W</b>  |   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH<br><b>12/28/1880</b>   |  |  | 9. AGE (In years last birthday)<br><b>85 yrs.</b>  |  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.              |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |  |   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Galestown Md.</b> |   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |  |   |  |  | 13. FATHER'S NAME<br><b>Wm. J. Wheatley</b>  |  |  |   |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Sarah J. Payne</b>  |  |  |   |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>                                   |  |  |   |   |  |
| 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |  |   |  |  | 17. INFORMANT<br><b>Mr. Ira Wheatley</b>   |  |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br><b>600.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pneumonia</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>4 weeks</b>  |  |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> , to <b>26 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>24 Nov</b> 19 <b>66</b> , and that death occurred at <b>9:25 P.M.</b> from the causes and on the date stated above.   |  |  |   |  |  |  |  |  |   |   |  |
| 22a. SIGNATURE<br><b>Stephen P. Carney</b>   |  |  |   |  |  | 22b. DATE SIGNED<br><b>11-28-66</b>  |  |  |   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>STEPHEN P. CARNEY</b>   |  |  |   |  |  | 22d. ADDRESS<br><b>EASTON, MD.</b>   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE THEREOF<br><b>11-29-66</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>E. New Market Cemetery</b>  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>E. New Market Md.</b>    |   |  |
| 24. FUNERAL DIRECTOR<br><b>Henrietta Howard J. Locant St. Cambridge Md.</b>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>  |  |  |   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |   |  |  | DATE<br><b>DEC 1 1966</b>  |  |  |   |   |  |

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16237

# CERTIFICATE OF DEATH

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Talbot</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>   |  | c. LENGTH OF STAY IN 1b <u>D.O.A.</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EASTON</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>  |  | d. STREET ADDRESS <u>'The Rest'</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM Norman Wherrett</u>   |  | 4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1966</u>  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W.</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 30, 1893</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>PROJECT ENGINEERING</u>   | 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD</u>                             |
| 13. FATHER'S NAME <u>WILLIAM GEORGE WHERRETT</u>   |  | 14. MOTHER'S MAIDEN NAME <u>MINNIE S. SMITH</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>  |  | 16. SOCIAL SECURITY NO. <u>712-038643</u>  | 17. INFORMANT Address <u>MRS. W. NORMAN WHERRETT EASTON, MD</u>                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO (b) <u>4201</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>                    </u> , 19 <u>  </u> , to <u>                    </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>                    </u> , 19 <u>  </u> , and that death occurred at <u>3:00 P</u> M, from causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE <u>Thurston Harrison</u>  |  | 22b. DATE SIGNED <u>26 Nov 66</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>  |  | 22d. ADDRESS <u>Easton, Maryland</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF <u>Nov. 28, 66</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE</u>  | 23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE BA. MD</u>                                |
| 24. FUNERAL DIRECTOR <u>W. H. H. H.</u>  |  | 25a. REC'D BY REGISTRAR DATE <u>NOV 28 1966</u>  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |

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